



## NHSC HONORS OUTSTANDING CLINICIANS IN FIRST ANNUAL AWARDS

*For 25 years, the community of clinicians that is the NHSC has gone where others have chosen not to go, providing care to the poorest, the least healthy and the most isolated of our fellow Americans.*

*Through the National Honor Awards we recognize those of our colleagues who by their actions exemplify the ideals of the NHSC: a commitment to primary care and a dedication to service to the underserved through a culturally competent, community-responsive, interdisciplinary team approach to patient care. Their achievements go beyond simply fulfilling their NHSC commitment, for they have demonstrated that their true commitment is to their community and its people.*

*I am sure that those people will join me and all the NHSC family in offering these honorees congratulations and a heart-felt thank you.*

Sincerely,  
 Donald L. Weaver, MD  
 Director, NHSC



The National Health Service Corps is a program of the Federal Health Resources and Services Administration's Bureau of Primary Health Care, which is the focal point for providing primary health care to underserved and vulnerable populations.



### Physician of the Year Mark William Tuccillo, DO

Petersburg Medical Center  
 Petersburg, Alaska

*In recognition for his outstanding contribution in stabilizing and returning quality health care to the community and surrounding areas of Petersburg, Alaska.*

In the rural hospital setting of Petersburg, Dr. Tuccillo initiated new patient procedures,

Continued on page 6

### REDUCING PATIENT STRESS: TELL THEM WHAT TO EXPECT

A rural patient is driven to the big city hospital after her local doctor discovers what may be sight-threatening macular degeneration.

By the time she gets to the hospital, she's frazzled. She and her companion missed the exit, drove through a bad neighborhood, and spiraled through the parking lot three times before finding a space.

Once inside, she's asked to fill in forms she can't see, told first to sit in one room then in another, and finally moved from technician to doctor to ophthalmic photographer, all of whom are busy and uncommunicative. When she finally meets the specialist, she's so anxious she can't

Continued on page 2

### INSIDE

Watching TB Disappear.....	3
Get a Feel for Underserved Sites.....	3
Strategies for Recruiting.....	4
NHSC Annual Conferences.....	7
Surfing the BPHC.....	8

# REDUCING PATIENT STRESS: TELL THEM WHAT TO EXPECT

Continued from page 1

understand what he's saying.

The patient's anxiety level is now at fever-pitch. This extreme anxiety has reduced her ability to deal with medical results and decreased her pain tolerance. It is basically unhealthy. And perhaps avoidable.

Even though some anxiety is often considered normal for outpatient treatment, overly high levels can be prevented. This is the conclusion Elizabeth Dunn and Carmhiel Brown came to after interviewing outpatients at Thomas Jefferson University Hospital in Philadelphia.

Dunn, Director of Market Development, and Brown, Associate Vice President for Marketing for the hospital, set out to do an outpatient satisfaction survey. Their first discovery was that, with 75 different outpatient procedures at the hospital, many of the experiences could not be compared.

However, after interviewing patients, they did uncover an important commonality. "No matter what the procedure, the dominant experience for the patient was anxiety," they wrote in the journal *Health Care Marketing*. The team also discovered that much of the anxiety could be mitigated through relatively simple changes in patient/staff interaction.

"Fears can be alleviated by letting patients know what to expect," says Dunn. The key is giving the patient a realistic picture of what's coming up.

The details of the procedures are often so routine to the practitioners that they don't

think about them, Dunn explains. But for many

patients everything from the color of the carpet to the sounds made by the equipment is new, different, and somewhat scary.

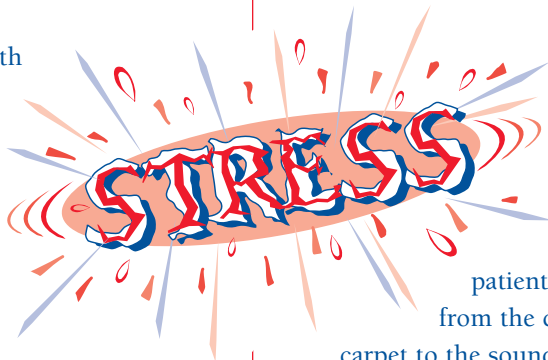
Dunn admits their work has been criticized for stating the obvious: patients are stressed. But, she says, the critics aren't reading carefully enough. Through their interviews, she and her partner pinpoint the eight most stressful moments patients experience as they go through the process, and provide suggestions on how to mitigate anxiety along the way (see box). The suggestions apply to staff in hospitals as well as clinics, one-room offices, homeless shelters, and other settings

where practitioners work with outpatients.

While patient preparation can make a real difference, it won't address every type of anxiety, note Dunn and Brown. Some of the problems are exacerbated by the procedures rather than caused by them. The authors offer a step-by-step plan to help decrease that type of stress too. These steps are:

- Acknowledge that the situation is stressful.
- Empathize with the patient.
- Explain what's going on and what's going to happen next.
- Give choices wherever possible.
- Check for understanding and ask if the patient has questions.

For example, a patient may be worried about finishing tests in time to pick up a child from day care. The authors suggest that staff acknowledge the difficulties, give the patient an estimate of how long the procedure will take, and offer the patient a phone to make other arrangements for the child. More suggestions are listed below. ■



## STRESSFUL MOMENTS...AND OPTIONS FOR RELIEF

After interviewing outpatients from Thomas Jefferson University Hospital, Elizabeth Dunn and Carmhiel Brown identified the eight most stressful moments—for patients—in medical procedures.

1. Patient is told he or she needs an outpatient procedure.
2. Patient schedules procedure and waits.
3. Patient prepares for procedure (e.g., fasts).
4. Patient travels to hospital.
5. Patient registers and waits in lobby.
6. Patient waits in procedure room.
7. Patient undergoes procedure.
8. Patient waits for results.

Dunn and Brown recommend a number of steps health care professionals can take to reduce patient stress and anxiety.

• **Provide Information:** Tell the patient about the procedure. When possible, provide a pamphlet. Tell the patient about the hospital, what it looks like, and where to park.

• **Change the Environment:** Many patients complain that the examination room is cold. Offer a blanket to a waiting patient. Provide light-hearted reading material to help the time pass.

• **Check on People Skills:** Update each waiting patient at least every eight minutes. Tell the patient how long the wait will be and what is causing the delay.

Source: "A Framework for Reducing Outpatient Anxiety" by Brown and Dunn. Published in *Health Care Marketing*, October 1995.

# WATCHING TB DISAPPEAR: PROGRAM CUTS TB RATE IN HALF

For many years, health care providers have been facing the reality that tuberculosis is not a disease of the past. Even as the TB increases of the 1980s have leveled out, many clinicians in health professional shortage areas face increased difficulties in treating the disease. For one reason or another, patients fail to complete the treatment and develop resistance to the medicine. According to NHSC's Chief Medical Officer, Dr. Richard Niska, TB is most dominant in large cities, yet also prevalent and difficult to treat in areas with migrant workers and Native Americans.

Health care providers in Baltimore, Maryland have found a way out of this cycle. Baltimore, a working-class city with several HPSAs within its borders, is known historically for its high TB rate. The city's problems of unemployment, poverty, drug-use and AIDS are conditions usually associated with a high risk of TB.

However, in the last decade, the port city has sent TB into a sharp decline using community-based Directly Observed Therapy (DOT).

Run by the Baltimore City Health Department, the TB Control Program uses teams of health care providers who go to a patient's home, workplace, or school to watch as the patient takes the medicine and to monitor the response.

In 1981, Baltimore had 35.6 cases of TB per 100,000 people. In 1992, the number had fallen to 17.2 cases per 100,000 people. By contrast, Atlanta, Georgia went from 39.7 cases per 100,000 people to 78.2 per

100,000 in the same time period.

"Directly Observed Therapy is predicated on the belief that by directly observing the patient consume all required medications, a full treatment regimen will be ensured, thereby reducing the risk of treatment failure and the emergence of drug resistance," Project Clinician C. Patrick Chaulk, MD, explains in the article he and his colleagues wrote for the *Journal of the American Medical Association*. While DOT has been used in other projects, Chaulk says the expansion from a clinic-based DOT to a community-based system had a significant impact on TB in Baltimore.

The program works as follows: Patients diagnosed with TB are assigned a case management team.

Team members arrange to meet patients and observe them take their medicine. Initially the meetings occur five days a week. Then they occur twice weekly until completion of the medical regimen.

Patients who do not make such an arrangement (10% of Baltimore's TB patients) receive DOT at the clinics.

Patients who miss appointments are pursued by the case management team and health investigators who can invoke legal measures including involuntary hospitalization.

In each year between 1986 and 1992, more than 90 percent of Baltimore's DOT patients completed therapy.

Baltimore's TB Control Program is paid for through a combination of local, State and Federal funds. ■

## GET A FEEL FOR UNDERSERVED SITES: WORK WITH THE HOMELESS

For many NHSC health care providers, the homeless population is an important clientele. These providers understand how health care and homelessness are intertwined.

"Homelessness causes health care problems," Wayne Anderson, Associate Director of the National Health Care for the Homeless Council told *The New Physician*. "And lack of appropriate health care or insurance may cause homelessness."

For NHSC scholars, helping to provide health care for the homeless is a good way of getting hands-on experience and researching potential practice sites. The resources listed below can help scholars—and others—get involved.

### Resources to Get Started:

#### Your School

Many health professional schools run clinics for the homeless. Check with your school advisers.

NHSC Fellowship of Primary Care Health Professionals  
800-221-9393

Some NHSC scholars have worked with the homeless as part of an intensive fellowship (see NHSC *In Touch* Spring 1996). Through NHSC's network of

partnerships, students and residents are placed by regional/State Primary Care Associations and Primary Care Offices. Some of the placements are in clinics that provide health care to the homeless. Call to request a list of programs and contact numbers.

Health Care for the Homeless (HCH)  
301-594-4430

<http://www.bphc.hrsa.dhhs.gov/hch/hch1.htm>  
A BPHC project, HCH funds hundreds of programs.

"Health Care for the Homeless," a Primary Care Project-in-a-Box from the American Medical Student Association's Generalist Physicians in Training.  
703-620-6600, ext 256.

National Coalition for the Homeless  
202-775-1322

1612 K St. NW #104  
Washington, DC 20006  
<http://www2.ari.net/home/nch/wwwhome.html>  
Representatives will describe ongoing programs and provide contact names and numbers.

National Healthcare for the Homeless Council

615-226-2292  
P.O. Box 68019  
Nashville, TN 37206-8019  
Representatives will provide information on projects, contact names and numbers.



## RECRUITING FOR THE UPPER-MIDWEST

**N**orth Dakota is not Minnesota. And Wisconsin is not Nebraska, Iowa, or South Dakota. Yet when it comes to recruiting for underserved areas, these upper-Midwest States are all for one and one for all.

The idea of joint recruiting goes against the grain for many recruiters. The task is, by definition, competitive. But for the primary care offices and associations of these six States, the benefits of cooperation outweigh the costs.

The six-State cooperative, called the Upper-Midwest Health Provider Placement Coalition, has been able to afford recruiting techniques usually used only by wealthy hospitals. They buy national mailing lists; set up booths at national meetings; and create databases of medical school students, residents, PAs and NPs in their own States.

"These are things that we can't do as individual States," explains Mary Amundson, who works for the University of North Dakota's Center for Rural Health and the State's Primary Care Office. But as a group, the States can—and do—make them work. Last year, North Dakota's Center for Rural Health went to its first national meeting, paying \$200 for its share of the booth.

Amundson ended up with five potential candidates for her State.

The logistics of the five-year-old network are relatively simple. Representatives from each State meet for two days twice a year. Throughout the year they maintain contact through such activities as buying the mailing lists and making referrals to each other. "If we can't place candidates in our State, we need to at least keep them in the regional network," Amundson says, expressing the coalition's attitude. She says she has received and provided many referrals for the coalition.

Those referrals are the worrisome part for would-be coalitions. What if you send people out, but no one sends them back? Or if you pay for a group booth and your material isn't put out?

"Trust is the most difficult part of it," answers Amundson, adding that her coalition meshed surprisingly well at their first meeting. This connection between members of the coalition is not to be taken for granted, she adds. She knows of other groups that haven't gotten off the ground because of basic interpersonal dynamics.

"You've really got to trust each other," she concludes. ■



## NHSC's STATE LOAN REPAYMENT PROGRAM

**N**ine years ago, West Virginia became one of the first seven States to start a State Loan Repayment Program. Of the 37 practitioners they have funded, 35 still work in the State's underserved areas.

West Virginia's remarkable retention record is due to careful screening of candidates, says Linda Atkins, Director for West Virginia's Special Project of Recruitment and Retention. She works almost exclusively with graduates from West Virginia schools, so the new practitioners are already familiar with the area.

The success is also due to flexibility built into the program, explains NHSC State Loan Repayment Program Coordinator Susan Salter. "This program gives the State more control than in the Federal program."

The differences between the two programs are slight, but significant. While both place practitioners in federally designated underserved sites and both use primary care practitioners, the Federal program is more restrictive.

The Federal program is a national system. States are not required to put up matching funds and are not

# AND KEEPING CLINICIANS

guaranteed practitioners. The Federal NHSC Loan Repayment Program has several restrictions on sites where their participants may practice. All Federal plan loan repayers work in federally designated health professional shortage area (HPSA) sites, but in addition, the sites must show that they are in urgent need of a practitioner, essentially competing with other HPSAs.

For NHSC's State Loan Repayment Program, State governments put up money, which the Federal government matches. States then distribute the funds to the practitioners, and the practitioners may work at any HPSA in the State.

Another difference, says Salter, has to do with the practitioners themselves. While both programs use primary care clinicians, officials for the Federal program determine which disciplines to fund by examining the overall, long-term needs of the country. However, the needs of the country may not match the needs of a particular State.

The State Loan Repayment program allows States to choose which disciplines they are going to fund to meet their own needs. For example, if State officials decide one year that they are facing a mental health crisis, they could fund a cadre of mental health practitioners that year.

State Loan Repayment Programs vary in size. West Virginia's program is on the small side, with a total budget of \$200,000, while California's program is budgeted at \$1 million. The joint payment system is a good deal for both the Federal and State governments, says Salter. "Each side gets a whole provider for half price." ■



## SOUTH DAKOTA FOUND A MIRROR DOESN'T WORK

**L**ike many rural States, South Dakota has a shortage of health care professionals. Over the years, the State has received Federal assistance in the form of NHSC providers. But in 1989 State officials decided they needed even more.

State officials designed a program that mirrored the Federal NHSC Scholarship program, explains Bart Hallberg, Community Development Coordinator, Office of Rural Health. The State provided scholarships for medical students at the University of South Dakota School of Medicine. In turn, the students committed to working in rural, underserved South Dakota sites. The program was open to all of the same primary care medical specialties as the Federal NHSC program.

Surprisingly, this turned out to be a problem for South Dakota.

NHSC's listing of health professional shortage areas includes both rural and urban sites. It is in the urban settings that Federal health care providers are most likely to use a full-time OB/GYN or internal medicine specialist.

South Dakota, on the other hand, is mostly rural. The State needs more family practitioners and fewer internists than the national plan,

says Hallberg.

A second problem, Hallberg notes, is that nurse practitioners and physician assistants were not considered in the original design of the program because they were not then as common in South Dakota as they are now.

An additional drawback of the program was that it required medical students to commit to a primary care discipline and a rural practice in South Dakota before they had explored other options.

In recent months, South Dakota officials have revised the program and are planning to change it even further, tailoring it more closely to South Dakota's needs, says Hallberg.

For the 54 students currently enrolled in the program, the State is broadening the criteria for underserved sites.

For the future, the State is looking at replacing the tuition waiver with what Hallberg calls an enhanced "back-ended" program. Instead of starting with medical school students, the program will target new doctors and offer them financial incentives to serve in South Dakota's underserved areas. This will allow the State to be in a better position to have sites available for everyone who is accepted in the program. In addition, says Hallberg, NPs and PAs will be eligible for funding from a similar program.

Hallberg presented the history of the South Dakota program last fall at a Bureau of Primary Health Care symposium. He says revisions are to be expected as the State continues to learn what works best.

"We saw a need, we attempted to meet that need," he says. "And now we're trying to make the program work." ■

# National Honor Awards

Continued from page 1

including cardiac stress testing and sigmoidoscopy. He introduced rural medicine rotations for medical students and family practice residents, and he continues to make house calls to isolated islands to see patients who have no physician available. He is a key person in the recruitment of additional permanent practitioners and serves on the Medical Center's quality assurance committee. In addition, Dr. Tuccillo manages to donate his time in ways that can only be described as pure dedication.

Outside of the hospital, Dr. Tuccillo serves as the Public Health Officer for the City of Petersburg. He initiated a telemedicine project with the University of Washington. He is the Emergency Medical Service Director to the ambulance service and provides lectures and hands-on training to EMTs. He also lectures high school students about AIDS and finds time to volunteer at the community health fair.



## Nurse Practitioner of the Year

**Mary Anne Meyer, FNP**  
Erie Family Health Center  
Chicago, Illinois

*In recognition of her dedication and compassion for the underserved clients to whom she provides primary health care services. Her approach to her patients is truly noteworthy.*

A bilingual provider, Ms. Meyer's dedication, energy and commitment to delivering high-quality services are remarkable. Her most significant contribution was her participation in the identification of the multi-drug resistant tuberculosis epidemic at her site. Working with the Chicago Department of Health, Ms. Meyer assisted in the screening, identifying, treatment and follow-up of individuals to curtail the epidemic. Ms. Meyer also works closely with HIV/AIDS clients. She stays current with the ever-changing area of HIV and is a resource person for physicians and nurse practitioners alike.

Ms. Meyer works closely with a team of physicians, nurses and case workers to ensure that comprehensive health care is available for her clients, implementing, for example, a comprehensive health care program at a methadone treatment center. In addition, she is active in the mentoring and orientation program for new nurse practitioners and helps recruit new personnel.

Ms. Meyer's resourcefulness is seemingly endless. When the children's waiting area required new toys, she hauled

out paper from trash receptacles to be recycled, generating enough money to purchase new toys.



## Physician Assistant of the Year

**Choi Mei Adams, PA**  
Health Care for the Homeless Project, Inc.  
Community Health Care Program  
Washington, D.C.

*In recognition of extraordinary personal efforts and sensitivity in providing health care and transition support to Vietnamese immigrants new to the Washington, D.C. community.*

Ms. Adams truly embraces the patients in the Community Health Center Program at the Upper Cardoza Health Center, providing the highest quality of care during the workday as well as during her free time. She accompanies frightened and weary patients who need the services of medical specialists and frequently makes home visits. She helps write resumes for those seeking employment and even funded the certified medical assistant education of a talented Vietnamese clerk who worked at the health center.



## Dentist of the Year

**Debra L. Edgerton, DDS**  
Ben Archer Health Center  
Hatch, New Mexico

*Recognition on a regional and national level for her contribution to the improvement of dental care for underserved populations in the frontier, rural areas of Dona Ana and Sierra Counties.*

In 1989, Dr. Edgerton was assigned to a site with one dentist, one hygienist and one dental assistant, serving primarily Hispanic and migrant patients. She learned to speak Spanish and began a crusade no one expected.

Dr. Edgerton was instrumental in adding to the program a pediatric dentist who works at both the hospital and the health center. Through Dr. Edgerton's creative utilization of resources, the pediatric dentist was brought on-board with no increase of funding.

She was also instrumental in establishing a dental clinic in Truth or Consequences, N.M., a community 40 miles north of Hatch, which previously had no dental services. Today it has two dentists, two hygienists and three assistants. Dr. Edgerton also helped both to acquire a dental health professional shortage area (HPSA) designation for Las

# National Honor Awards

Cruces and to staff the facility.

Dr. Edgerton has overseen the design of the clinics, the purchasing of equipment and the hiring of personnel. These clinics are regarded as models for the implementation of Occupational Safety and Health Administration (OSHA) standards.



## Dental Hygienist of the Year

**Donna J. Richards, RDH**

Lynn C. Gilbert Dental Clinic  
Grantsville, West Virginia

*For dedicated service to the school children of Calhoun County, West Virginia.*

In addition to her 40-hour clinical work week as the first and only dental hygienist in Calhoun County, Ms. Richards spearheaded an Anti-Tobacco Campaign in a community with the highest teenage tobacco use in West Virginia. She used her spare time to visit every school in the service area, discussing the prevention of oral disease. She also helped to raise over \$5,000, which was used to apply dental sealants on the teeth of uninsured children whose family income fell 200% below the Federal poverty level.

## NHSC Annual Conferences

Mark your calendar to attend one of the five NHSC Annual Conferences for scholars and providers. For more information call 1-800-646-5317

<b>May 30-June 1, 1997</b>	<b>202-737-1234</b>
Hyatt Regency Washington 400 New Jersey Ave. NW Washington, DC 20001	
<b>July 31-August 2, 1997</b>	<b>602-963-6555</b>
Sheraton San Marcos One San Marcos Place Chandler, AZ 85224	
<b>September 11-14, 1997</b>	<b>214-651-1234</b>
Hyatt Regency Dallas at Reunion 300 Reunion Blvd. Dallas, TX 75207	
<b>November 21-23, 1997</b>	<b>202-393-1000</b>
Capitol Hilton 16 & K Street, NW Washington, DC 20036	
<b>January 30-February 1, 1998</b>	<b>404-881-8000</b>
Renaissance Atlanta Hotel 590 West Peachtree Street, NW Atlanta, GA 30308	



Members of the Interdisciplinary Primary Care Team of the Year gathered in front of their mobile work station. Above: Esmine Leonard, RN; Steven Diaz, EMT; and Karen Coutrier, PNP. Left: Anne Beal, MD; Karen Coutrier, PNP. Not shown: Jose Wendel, RD; Jennifer Seabrook.

## Interdisciplinary Primary Care Team of the Year

**Karen Coutrier, PNP; Anne Beal, MD; Jose Wendel, RD; Esmine Leonard, RN; Jennifer Seabrook; Steven Diaz, EMT**

The New York Children's Health Project  
New York, New York

*In recognition for providing outstanding, high-quality primary care for some of the most medically underserved children in the nation.*

The New York Children's Health Project (NYCHP), an innovative, comprehensive primary care pediatric program, is the nation's largest health care provider system for homeless children. This extraordinary team of professionals provides health care at the Kennedy Inn homeless family shelter.

The team focuses on primary care and works diligently to ensure continuity in follow-up visits. Acutely aware of the multiple needs of these families, the team has organized many additional services, including nutritional and cooking classes for mothers, anti-violence seminars and self-esteem workshops for teens, medical screening programs, and a program that helps families identify primary care providers in new neighborhoods once permanent housing is found.

Team members assist families as advocates for improving conditions in the shelter system, and represent a profoundly important human connection to the lives and futures of these families. Visitors to the site are unfailingly moved by the quality of the relationships between the team members and their patients. Their work exemplifies the philosophy and spirit of the National Health Service Corps. ■

## SURFING WITH THE BPHC: WEB SITE MADE MORE ACCESSIBLE

**G**etting information about Bureau of Primary Health Care (BPHC) programs just got easier. A newly updated Web site invites visitors to log onto ACCESS from the

BPHC home page. Formerly, BPHC ACCESS could only be reached through the "800" dial-up BPHC ACCESS. BPHC staff expect the new Web site to reach a broader audience.

Web site features include bulletins about HRSA Field Offices, a request for non-federal reviewers, and a forum (electronic bulletin board) for people interested in the Bureau's activities.

Another feature is access to the BPHC databases. The topics covered include:

**Models That Work:** Abstracts of projects that won the national competition of successful, implementable programs.

**BPHC Programs:** A database that allows visitors to retrieve programs by State, city or name.



**HPSA:** A current list of health professional shortage areas.  
**Drug Pricing Database:** A database that allows clinicians to check discount availability, searchable by State, city or name.

In addition to the Web site upgrade, BPHC staff have improved the "800" dial-up BPHC ACCESS. The system is now faster and Internet mail is being sent through a direct connection. Once connected, visitors who use dial-up ACCESS can download a special Web browser to use on the Web ACCESS. BPHC's Web site is: <http://www.bphc.hrsa.dhhs.gov> While you're there, check out NHSC's Web site: <http://www.bphc.hrsa.dhhs.gov/nhsc/nhsc.htm> ■

*NHSC In Touch* is produced by The NHSC Recruitment/Retention Marketing Program. Questions or comments should be directed to NHSC *In Touch*, 5454 Wisconsin Avenue, Suite 1300, Chevy Chase, MD 20815; tel.: 301-951-9200; fax: 301-986-1641; e-mail: [dan.tisch@access.gov](mailto:dan.tisch@access.gov). Nancy Low & Associates, Inc., operates the Recruitment/Retention Marketing Program for the National Health Service Corps, Bureau of Primary Health Care, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services, under Contract No. HRSA 240-94-0043. The views and opinions expressed do not necessarily represent the official position or policy of the U.S. Department of Health and Human Services.

DEPARTMENT OF HEALTH & HUMAN SERVICES

U.S. PUBLIC HEALTH SERVICE

HEALTH RESOURCES AND SERVICES ADMINISTRATION

BUREAU OF PRIMARY HEALTH CARE

NATIONAL HEALTH SERVICE CORPS

RECRUITMENT/RETENTION MARKETING PROGRAM

SUITE 1300

5454 WISCONSIN AVENUE

CHEVY CHASE, MD 20815



First-Class Mail  
Postage and Fees  
Paid  
PHS/HRSA  
Permit No. G-286

Official Business

Penalty for Private Use \$300

**Visit NHSC's Web Site!**

<http://www.bphc.hrsa.dhhs.gov/nhsc/nhsc.htm>